STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155777	A. BUILDING 00 B. WING	04/15/2011

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CREASY SPRINGS HEALTH CAMPUS	1750 S CREASY LANE LAFAYETTE, IN47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: April 11, 12, 13, 14, and 15, 2011 Facility number: 012285 Provider number: 155777 AIM number: 201006770 Survey Team: Megan Wyant, RN, TC Linda Campbell, RN Brenda Nunan, RN Census bed type: SNF: 36 Residential: 40 Total: 76 Census payor type: Medicare: 29 Medicaid: 0 Other: 47 Total: 76 Sample: 10	F0000	Creasy Springs Health Campus1750 S. Creasy LaneLafayette, IN 47905Survey Event ID: R2L311The submission of this POC does not indicate an admission by Creasy Springs Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Creasy Springs Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs).To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Supplemental sample: 1 Residential Sample: 7 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review 4/20/11 by Suzanne Williams, RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to ensure the physician was notified in a timely manner related to the inability to obtain a sputum specimen for a laboratory culture for 1 of 1 resident with a sputum culture order in a sample of 10. (Resident #27).	F0157	CORRECTIVE ACTIONResident #27 was admitted to the facility on 3-30-11 and admitted to hospice on 4-7-11. The physician and hospice were notified on 4-12-11 of the staff's inability to obtain the sputum culture as noted in the nurses notes on 4-12-11. On 4-13-11 the physician was again notified of inability to obtain the	05/15/2011

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	Findings include: Resident #27's clinical record was reviewed on 4/11/11 at 10:10 A.M. The resident was admitted with diagnoses which included, but were not limited to, recent pneumonia, non-ischemic arteriosclerotic heart disease, and left parietal infarct. A hospital discharge summary dated 3/30/11 indicated "recent methicillin resistant staphylococcus aureus pneumonia." A physician's order dated 4/6/11 indicated "sputum culture." A review of laboratory reports from 4/6/11 through 4/14/11 indicated documentation was lacking related to the sputum culture had been done. Review of lab tracking forms dated 4/6/11 through 4/12/11 indicated the sputum specimen was unable to be collected and the culture was not done. Further review indicated the form "MD notified" was blank. Nurses' notes dated 4/6/11 through 4/11/11 indicated documentation was lacking related to the physician being notified of the inability to obtain the		sputum culture and was asked if he wished a nasal tracheal sputum obtained, which the physician refused. On 4-13-11 the physician ordered to obtain the sputum culture if the resident produces sputum. The resident did not have a productive cough that allowed the sputum to be collected. This hospice resident did expire on 4-22-11. IDENTIFY OTHER RESIDENTSIn an audit of lab forms for all other health center residents no other residents had orders for a culture that had not been able to be obtained.MEASURES/SYSTEMIC CHANGESLicensed nursing staff will be in-serviced on the physician notification policy and procedure.MONITORING CORRECTIVE ACTIONThe DHS or designee will monitor labs daily Monday through Friday at the Clinical Meeting to ensure physician notification if staff unable to obtain the ordered lab. Findings will be reported to and reviewed by the QA Committee monthly for 3 months.	

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	sputum specimen for culture. Interview on 4/12/11 at 9:15 A.M. with LPN #1 indicated she was unaware if the sputum culture had been done or if the physician had been notified. She indicated the physician should have been notified. Interview on 4/13/11 at 1:25 P.M. with the MDS coordinator indicated she was unable to find any documentation related to the physician being notified of the inability to obtain the sputum for culture. She indicated he should have been notified "the next day." Interview on 4/14/11 at 10:20 A.M. with the Director of Health Services indicated the physician had been notified "verbally" but it was not documented. Review on 4/14/11 at 2:10 P.M. of a facility policy and procedure dated 12/6/2007 and titled "Physician Notification Guidelines" indicated "...resident assessments for change in condition, suspected injury, event of unknown origin or ordered lab and/or other diagnostic test should be completed in a timely manner...attempts to notify the physician and their response should be documented in the resident record...." 3.1-5(a)(3)			

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F0176 SS=D	An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. Based on observation, record review and interview, the facility failed to ensure a resident could safely self-administer medication for 1 of 1 resident reviewed for self-medication in a sample of 10 residents (Resident # 21). Findings include: The clinical record for Resident #21 was reviewed on 4/11/11 at 10:05 a.m. Diagnoses included, but were not limited to, penile cancer with total penectomy, depression, congestive heart failure and history of alcohol abuse. An "ASSESSMENT REVIEW AND CONSIDERATIONS," dated 03/29/2011, indicated, "...Self Medication: ...No plan of care is necessary at this time...."	F0176	CORRECTIVE ACTIONThe medications were removed from resident #21's room on 4-11-11. IDENTIFY OTHER RESIDENTSAll other health center resident's rooms were audited and no other medications were found at the bedside. MEASURES/SYSTEMIC CHANGESLicensed nursing staff will be in-serviced regarding the importance of observing for any medications at the bedside of the resident. If observed, medications are to be removed and the nurse will evaluate the resident for self-administration of the medications. Additionally an insert is being prepared for the admission packet for residents and family members educating them that residents may not have medications at the bedside without a self-administration assessment being completed. Residents and families will be asked not to bring medications to the resident. If the family brings any items for resident use, including over-the-counter items, they will be asked to take the items to the nurses' station first for assessment. MONITORING CORRECTIVE ACTIONNursing staff will audit resident rooms daily to ensure no medications	05/15/2011

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	A physician's recapitulation, dated 03/29/2011, indicated, "...Ventolin inhale (SIC) Q (every) 4 (symbol for hours) ii (two) puffs (for) wheezing...." A physician's order, dated 04/01/2011, indicated, "...MOM (Milk of Magnesia) 60 cc (cubic centimeters) po (oral) now & qd (every day) prn (as needed) (for) constipation...." A MDS assessment dated, 04/05/2011, indicated the resident was cognitively intact. During observations on 04/11/2011 at 9:30 a.m. and 10:45 a.m., Resident # 21 had one bottle of Milk of Magnesia and one Ventolin inhaler at the bedside. The resident indicated he had used both medications since admission to the facility. During an interview on 04/11/2011 at 10:45 a.m., RN # 5 indicated medications should not have been		are at the bedside without a self-administration assessment having been completed. An audit checklist will be provided to the Director of Health Services or designee daily Monday through Friday, and will be reported to the QA Committee monthly for 3 months.	

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	at a resident's bedside unless the resident had been assessed for safe self medication administration. During an interview on 04/11/2011 at 10:50 a.m., Clinical Care Coordinator #10 indicated the resident should not have medications stored at the bedside until he had been assessed for safe self medication administration. An undated policy, titled "CLINICAL DOCUMENTATION SYSTEMS Admission Nursing Assessment and Data Collection" was provided by the Executive Director on 04/14/2011 at 1:45 p.m. The policy indicated, "...The assessment shall include identification of risk factors through assessment, observation and review of pertinent documentation that may contribute to additional complications, medical decline or safety concerns...." 3.1-11(a)			

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F0223 SS=D	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident remained free from verbal abuse related to intimidation and harassment. This deficient practice affected 1 of 2 abuse allegations reviewed, and 1 discharged resident in a supplemental sample of 1 reviewed for abuse. (Resident #38, LPN #6, CNA #9) Findings include: Review of an abuse allegation provided by the Executive Director on 4/14/11 at 1:10 p.m., indicated the following: A "fax/incident report" dated March 6, 2011 indicated "...Brief description of incident...(Resident #38's name) reported at 10:00 am on 3/6/11 that the night shift nurse (LPN #6) last night yelled at her because (the resident) requested a female staff member to help (the resident) to the BR (bathroom) instead of the male staff member that answered her call light. When the resident asked the nurse (LPN	F0223	CORRECTIVE ACTIONAll employees are educated to the facility's policies and procedures regarding abuse and neglect and resident rights at the time of hire in New Employee Orientation. The facility policy requires screening of employees, training of employees, prevention steps and identification steps that include prompt reporting of all resident allegations of abuse. If an allegation is made the first priority is immediate provision of safety for residents that may include moving the resident to another room, providing one-on-one monitoring if appropriate, or suspending the suspected employee(s) pending outcome of investigation. An investigation is immediately initiated as well as prompt reporting to the physician, family member, Triogy management and state agencies. All residents at the time of admission are informed of the facility's zero tolerance for abuse standard and how residents may report any concerns they experience while residing at the campus. The Executive Director and Director of	05/15/2011

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	#6) to leave (the resident's) room (the resident) states the nurse did not leave at first and was argumentative... Resident states she does not want this nurse caring for her again...Immediate action taken...the night nurse and male CNA (CNA #9) did ask a female CNA to provide care for the resident the remainder of the night shift to alleviate the resident's concern about having a male caregiver. Immediately upon the resident reporting the incident to the Social Services Director (SSD) the SSD contacted the Director of Health Services (DHS) who supervises the nursing staff. The DHS immediately contacted the night nurse (LPN #6) and the male CNA (CNA #9) and they were both placed on suspension pending completion of a full investigation of the incident...Preventative measures taken...The DHS contacted the Executive Director (ED) to apprise her of the resident's concern. The ED contacted the resident's POA/son to make him aware of the resident's concerns, the facility's actions taken to protect the resident and the on-going investigation into the resident's concerns. An in-service on the abuse and neglect policies of the campus was initiated for all staff on 3-6-11...The Social Services Director and ED met with the resident at separate times the afternoon of 3-6-11 and the resident had several visitors and was smiling an		Health Services did take appropriate action immediately when informed of the resident's allegations by suspending the nurse and CNA working on the shift at the time of the incident and initiating an immediate investigation into the resident's allegations. The incident was reported timely within 24 hours to the Indiana State Department of Health. IDENTIFY OTHER RESIDENTSThe Social Service Director on 3-6-11 did interview all other alert and oriented residents in the health campus and asked if they had any concerns with how staff had treated them or their care. No other residents expressed any mistreatment or concern to the Social Service Director. MEASURES/SYSTEMIC CHANGESEducation for staff was initiated on 3-6-11 for staff from all departments regarding the facility's policies and procedures on abuse and neglect and the importance of any staff member becoming aware of a resident concern to promptly report that to the Executive Director and/or the Director of Health Services so appropriate steps can be taken per facility policy to protect the resident that include suspending the suspected employee(s) pending outcome of investigation. All department staffs will be in-serviced on the abuse and neglect policies and procedures including the requirement to promptly report	

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	interacting with them and showed no signs of distress...." An investigation summary dated March 11, 2011, signed by the ED was provided on 4/14/11 at 4:30 p.m., by the ED and indicated "...The Social Service Director also interviewed all alert and oriented residents on 3-6-11 on the hallway where the nurse (LPN #6) worked to ensure no other residents were concerned with conduct of staff. No other residents reported any concerns with any staff members...During multiple investigative interviews with the resident at different times and with different individuals this resident was consistent in...recollection of the events that happened early in the morning of 3-6-11. At approximately 12:15 am the resident placed...call light on. The male CNA (CNA #9) on duty entered the room to assist (the resident). When (the resident) realized he was a man, the resident requested that a female CNA assist her as she was uncomfortable with a male caregiver. The male CNA assured the resident that he understood and he left the room and informed his charge nurse. The charge nurse (LPN #6) both acknowledges that the male CNA informed her of the resident's request and both the resident and the charge nurse acknowledge that the charge nurse entered the room alone to talk with the resident.		any allegations.MONITORING CORRECTIVE ACTIONEach month at Resident Council residents are educated regarding their rights including the right to be free from any mistreatment including abuse and neglect and asked if they have any concerns. Any resident allegations of suspected abuse will be immediately investigated and all appropriate and required actions will be implemented including the immediate suspension of the suspected employee(s) pending outcome of the investigation. All investigations are documented and reported immediately to Trilogy division support including outcome of the investigation and action steps taken. Additionally, all allegations of abuse are reported to the QA committee monthly and the QA committee will review each allegation to ensure the facility policy and procedure was followed. Should negative trends be noted the QA committee will report those findings to Trilogy Division Support for additional training and corrective action.	

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	The resident maintains that the charge nurse began talking to her in an inappropriately loud voice, telling the resident that (the resident) needed to allow the male CNA to provide care for (the resident) because he was scheduled for that hall to care for the resident and knew how to. The resident indicates that at not time during the conversation did the female charge nurse offer to assist the resident to the bathroom herself The resident states that the charge nurse continued to be argumentative with her about the caregiver status, allowing the conversation to escalate in both tone and content. The resident asked the charge nurse to leave her room and the charge nurse did not immediately comply with that request, causing an increase in the resident's anxiousness. After an additional conversation the charge nurse did leave the room and sought a female caregiver but the resident was distressed and anxious by this point. The charge nurse states in investigative interview that she did offer to take the resident to the bathroom; however the resident remains adamant that she did not. The charge nurse states that she did not yell at the resident but the resident has remained consistent that the nurse did yell at her and was argumentative with her. Investigative interviews were conducted with all staff members working to provide			

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	care for the resident on the night shift the event occurred. The male and female CNA's that cared for the resident the night of 3-6-11 also noted in investigative interviews that the resident expressed concern to them about how the charge nurse talked to her. The charge nurse does acknowledge that she did not leave the resident's room the first time the resident asked. During investigative interviews with the resident, (the resident) clearly recalled how anxious and fearful this conversation made her that evening because of the interaction with the nurse. The resident remained consistent in...praise for the CNA's, stating they were wonderful when they provided care...and ensured (the resident) was cared for the remainder of the night. The resident had no concerns regarding any other staff members or...care other than the charge nurse on duty the early morning of 3-6-11. Based on the results of the investigation, the male CNA received performance counseling and education regarding the importance of him communicating immediately any concerns regarding violation of resident's rights or abuse or neglect and he was allowed to return to work. Based on all the investigative interview, the campus had no alternative but to terminate the nurse based on her failure to honor the resident's rights to have an environment free of harassment			

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and intimidation that provides the resident choice about treatment and care and dignity...."

A statement dated March 6, 2011 from CNA #9 indicated "...Resident #38 (name) put on...call light, CNA #9 answered. (The resident) stated she preferred a female for her privacy. CNA # 9 went to get LPN #6, then CNA #9 went to the bathroom. When CNA #9 came back LPN #6 had already had some sort of confrontation with her, he had not witnessed. Call light 2nd time..Resident #38 (name) grabbed CNA #9's hand and kept holding it, and kept apologizing (sic) to him, she kept saying LPN #6 had been so awful to her, and wouldn't leave the room. Resident #38 (name) said she herself used some unladylike words because LPN #6 (name) wouldn't leave...call light 3rd time...asked to use bedpan...CNA #9 told her he would get (female caregiver)...Resident #38 (name) said no, it was okay for CNA #9 to help her...so CNA #9 (name) helped (Resident #38) on and off bedpan...LPN #6 (name) out at nurse's station...mad, and talked to CNA #9 (name)...'maybe I was raising my voice too loud. Kept focusing on it, over and over, said I feel bad, maybe I was too loud with her'..."

An undated, unsigned statement from

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	LPN #6 indicated "...at 0015 am (12:15 a.m.), Resident put on call light. Aide went in- resident wanted to go to BR but did want him to help-I went to help resident-Told her I was here to help but wanted to tell her that CNA #9 (name) was an employee and it was part of his job- and she should not worry- She refused to let me help said I was yelling at her and reprimanding her I tried to calm her and she became belligerent + was using foul language- Told me to get the hell our of her room that she didn't need my s**t- Asked her not to use that language that it was not necessary- She told me then to get the f**k out of her room- that is when I left her room and summoned (female CNA) to come and take her to BR- 1 hour later she put her call light on...said she thought maybe CNA #9 (name) would come in and put her on bed pan...." Review of LPN #6's employee file on 4/15/11 at 8:45 a.m., indicated the nurse had been inserviced on abuse and resident rights for the 2010-2011 calendar year. The file indicated the LPN had not received any disciplinary counseling related to abuse or resident rights prior to 3/10/11. The file further indicated a back ground check had been completed on the LPN and no violations were identified.			

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	An employee counseling record form dated 3/10/11 indicated "...LPN #6 (name) violated the resident's rights to have an environment free of harassment and intimidation that provides the resident choice about treatment and care and dignity. Additionally she failed to provide care for the resident directly and to meet the resident's needs when she could have...avoid the situation. LPN #6 (name) did not meet the facility's requirements, code of conduct or professional standards in her interaction and attitude displayed with the resident. The campus has not alternative but to immediately terminate employment...." Review of time sheet punches provided by the Executive Director on 4/15/11 at 11:45 a.m., indicated LPN #6 did not work in the facility after her shift on 3-6-11. Resident #38's record was reviewed on 4/15/11 at 10:20 a.m. The record indicated the resident was admitted to the facility on 4/4/11. The record indicated the resident was her own person and was alert and oriented x 3. A nurses' note signed by LPN #6, dated 3/6/11 at 12:15 a.m., indicated "...Resident put call light on to go to restroom. When male aide entered she			

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	did not want him help her (sic)- writer went in room to assist- Attempted to explain that male aide was an employee- Resident became very defensive + belligerent- using foul language- accusing writer of yelling at her + using foul language c (with) her- writer left room and summoned aid (sic) from another hall to assist- When aid (sic) helped her she stated male aid (sic) could be in her room anytime...." A nurses' note dated 3/6/11 at 9:00 a.m., indicated "...Writer observed (resident) to be tearful this morning. S/S (Social Services) her today et (and) notified of tearfulness...." During an interview with the Social Services Director (SSD) on 4/15/11 at 11:20 a.m., she indicated she went into the resident's room to introduce herself to her as she was a newly admitted resident. She indicated it was at that time the resident shared with her the concern she had related to LPN #6. She indicated the resident reported the nurse had been harsh in her manner of talking and was loud. The SSD indicated she immediately reported the resident's concern to the DHS and the ED. She indicated the LPN and CNA were suspended pending the investigation. She indicated the LPN's behavior and interaction with the resident			

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	was inappropriate. During an interview with the Executive Director on 4/15/11 at 11:45 a.m., she indicated the LPN could have eliminated the situation had she provided the resident care. The ED indicated she did not initially identify the altercation as abusive as the nurse did not enter the room with the willful intent to abuse the resident. She indicated she did not consider the altercation as neglect as the LPN did ensure care was provided to the resident by a female CNA. She indicated the LPN caused the resident anxiety because she did not immediately comply with her request for a female caregiver. She indicated the verbal altercation became willful when the LPN did not leave the resident's room upon the resident's request. She indicated the LPN made 2 very poor judgements by not providing care to the resident and by not leaving the room. An undated policy and procedure titled "Abuse and neglect procedural guidelines" provided by the ED on 4/11/11 at 9:20 a.m., identified as current indicated "...Trilogy Health Services (THS) has implemented processes in an effort to provide a comfortable and safe environment...Verbal abuse-may include oral, written or gestured language that			

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	include disparaging and derogatory terms to the resident/patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability... i. Staff to resident- any episode..." 3.1-27(b)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure an incident of verbal abuse, intimidation and harassment between a staff member and a resident was immediately reported and	F0225	CORRECTIVE ACTIONAll employees are educated to the facility's policies and procedures regarding abuse and neglect and resident rights at the time of hire in New Employee Orientation.	05/15/2011

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	investigated. The alleged staff member worked the remainder of the shift after the incident occurred. This deficient practice affected 1 of 2 abuse allegations reviewed, and 1 discharged resident in a supplemental sample of 1 reviewed for abuse. (Resident #38) Findings include: Review of an abuse allegation provided by the Executive Director on 4/14/11 at 1:10 p.m., indicated the following: A "fax/incident report" dated March 6, 2011 indicated "...Brief description of incident...(Resident #38's name) reported at 10:00 am on 3/6/11 that the night shift nurse (LPN #6) last night yelled at her because (the resident) requested a female staff member to help (the resident) to the BR (bathroom) instead of the male staff member that answered her call light. When the resident asked the nurse (LPN #6) to leave (the resident's) room (the resident) states the nurse did not leave at first and was argumentative... Resident states she does not want this nurse caring for her again...Immediate action taken...the night nurse and male CNA (CNA #9) did ask a female CNA to provide care for the resident the remainder of the night shift to alleviate the resident's concern about having a male caregiver.		The facility policy requires screening of employees, training of employees, prevention steps and identification steps that include prompt reporting of all resident allegations of abuse. If an allegation is made the first priority is immediate provision of safety for residents that may include moving the resident to another room, providing one-on-one monitoring if appropriate, or suspending the suspected employee(s) pending outcome of investigation. An investigation is immediately initiated as well as prompt reporting to the physician, family member, Triogy management and state agencies. All residents at the time of admission are informed of the facility's zero tolerance for abuse standard and how residents may report any concerns they experience while residing at the campus. The Executive Director and Director of Health Services did take appropriate action immediately when informed of the resident's allegations by suspending the nurse and CNA working on the shift at the time of the incident and initiating an immediate investigation into the resident's allegations. The incident was reported timely to the Indiana State Department of Health. The CNA was counseled and in-serviced on 3-7-11 regarding resident abuse and fully understands the need to report	

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	Immediately upon the resident reporting the incident to the Social Services Director (SSD) the SSD contacted the Director of Health Services (DHS) who supervises the nursing staff. The DHS immediately contacted the night nurse (LPN #6) and the male CNA (CNA #9) and they were both placed on suspension pending completion of a full investigation of the incident...Preventative measures taken...The DHS contacted the Executive Director (ED) to apprise her of the resident's concern. The ED contacted the resident's POA/son to make him aware of the resident's concerns, the facility's actions taken to protect the resident and the on-going investigation into the resident's concerns. An in-service on the abuse and neglect policies of the campus was initiated for all staff on 3-6-11...The Social Services Director and ED met with the resident at separate times the afternoon of 3-6-11 and the resident had several visitors and was smiling an interacting with them and showed no signs of distress...." An investigation summary dated March 11, 2011, signed by the ED was provided on 4/14/11 at 4:30 p.m., by the ED and indicated "...The Social Service Director also interviewed all alert and oriented residents on 3-6-11 on the hallway where the nurse (LPN #6) worked to ensure no		immediately any suspected incidents in the future. IDENTIFY OTHER RESIDENTSThe Social Service Director on 3-6-11 did interview all other alert and oriented residents in the health campus and asked if they had any concerns with how staff had treated them or with their care. No other residents expressed any mistreatment or concern to the Social Service Director. MEASURES/SYSTEMIC CHANGESEducation for staff was initiated on 3-6-11 for staff from all departments regarding the facility's policies and procedures on abuse and neglect and the importance of any staff member becoming aware of a resident concern to promptly report that to the Executive Director and/or the Director of Health Services so appropriate steps can be taken per facility policy to protect the resident that include suspending the suspected employee(s) pending outcome of investigation. All department staffs will be in-serviced on the abuse and neglect policies and procedures including the requirement to promptly report any allegations.MONITORING CORRECTIVE ACTIONEach month at Resident Council residents are educated regarding their rights including the right to be free from any mistreatment including abuse and neglect and asked if they have any concerns. Any resident allegations of	

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	other residents were concerned with conduct of staff. No other residents reported any concerns with any staff members...During multiple investigative interviews with the resident at different times and with different individuals this resident was consistent in...recollection of the events that happened early in the morning of 3-6-11. At approximately 12:15 am the resident placed...call light on. The male CNA (CNA #9) on duty entered the room to assist (the resident). When (the resident) realized he was a man, the resident requested that a female CNA assist her as she was uncomfortable with a male caregiver. The male CNA assured the resident that he understood and he left the room and informed his charge nurse. The charge nurse (LPN #6) both acknowledges that the male CNA informed her of the resident's request and both the resident and the charge nurse acknowledge that the charge nurse entered the room alone to talk with the resident. The resident maintains that the charge nurse began talking to her in an inappropriately loud voice, telling the resident that (the resident) needed to allow the male CNA to provide care for (the resident) because he was scheduled for that hall to care for the resident and knew how to. The resident indicates that at not time during the conversation did the female charge nurse offer to assist the		suspected abuse will be immediately investigated and all appropriate and required actions will be implemented including the immediate suspension of the suspected employee(s) pending outcome of the investigation. All investigations are documented and reported immediately to Trilogy division support including outcome of the investigation and action steps taken. Additionally, all allegations of abuse are reported to the QA committee monthly and the QA committee will review each allegation to ensure the facility policy and procedure was followed. Should negative trends be noted the QA committee will report those findings to Trilogy Division Support for additional training or corrective action.	

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	resident to the bathroom herself The resident states that the charge nurse continued to be argumentative with her about the caregiver status, allowing the conversation to escalate in both tone and content. The resident asked the charge nurse to leave her room and the charge nurse did not immediately comply with that request, causing an increase in the resident's anxiousness. After an additional conversation the charge nurse did leave the room and sought a female caregiver but the resident was distressed and anxious by this point. The charge nurse states in investigative interview that she did offer to take the resident to the bathroom; however the resident remains adamant that she did not. The charge nurse states that she did not yell at the resident but the resident has remained consistent that the nurse did yell at her and was argumentative with her. Investigative interviews were conducted with all staff members working to provide care for the resident on the night shift the event occurred. The male and female CNA's that cared for the resident the night of 3-6-11 also noted in investigative interviews that the resident expressed concern to them about how the charge nurse talked to her. The charge nurse does acknowledge that she did not leave the resident's room the first time the resident asked. During investigative			

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	interviews with the resident, (the resident) clearly recalled how anxious and fearful this conversation made her that evening because of the interaction with the nurse. The resident remained consistent in...praise for the CNA's, stating they were wonderful when they provided care...and ensured (the resident) was cared for the remainder of the night. The resident had no concerns regarding any other staff members or...care other than the charge nurse on duty the early morning of 3-6-11. Based on the results of the investigation, the male CNA received performance counseling and education regarding the importance of him communicating immediately any concerns regarding violation of resident's rights or abuse or neglect and he was allowed to return to work. Based on all the investigative interview, the campus had no alternative but to terminate the nurse based on her failure to honor the resident's rights to have an environment free of harassment and intimidation that provides the resident choice about treatment and care and dignity...." A statement dated March 6, 2011 from CNA #9 indicated "...Resident #38 (name) put on...call light, CNA #9 answered. (The resident) stated she preferred a female for her privacy. CNA # 9 went to get LPN #6, then CNA #9 went to the			

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	bathroom. When CNA #9 came back LPN #6 had already had some sort of confrontation with her, he had not witnessed. Call light 2nd time..Resident #38 (name) grabbed CNA #9's hand and kept holding it, and kept apologizing (sic) to him, she kept saying LPN #6 had been so awful to her, and wouldn't leave the room. Resident #38 (name) said she herself used some unladylike words because LPN #6 (name) wouldn't leave...call light 3rd time...asked to use bedpan...CNA #9 told her he would get (female caregiver)...Resident #38 (name) said no, it was okay for CNA #9 to help her...so CNA #9 (name) helped (Resident #38) on and off bedpan...LPN #6 (name) out at nurse's station...mad, and talked to CNA #9 (name)...'maybe I was raising my voice too loud. Kept focusing on it, over and over, said I feel bad, maybe I was too loud with her'..." Documentation was lacking to indicate CNA #9 immediately reported to facility management the concern the resident shared with him in the early morning of 3/6/11, about LPN #6 having yelled and been awful to the resident. An "Employee counseling form" dated 3/7/11 for CNA #9 indicated "...Employee was working the night of alleged verbal abuse sustained by Resident #38 (name).			

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	Upon notification of suspected verbal abuse, employee was immediately suspended pending investigation. Employee was found to have not been present during alleged verbal abuse altercation between LPN #6 (name) and Resident #38 (name)...Employee has been counseled and inserviced regarding resident abuse and fully understands the need to report immediately any suspected incidents in the future...." Resident #38's record was reviewed on 4/15/11 at 10:20 a.m. The record indicated the resident was admitted to the facility on 4/4/11. The record indicated the resident was her own person and was alert and oriented x 3. A nurses' note signed by LPN #6, dated 3/6/11 at 12:15 a.m., indicated "...Resident put call light on to go to restroom. When male aide entered she did not want him help her (sic)- writer went in room to assist- Attempted to explain that male aide was an employee- Resident became very defensive + belligerent- using foul language- accusing writer of yelling at her + using foul language c (with) her- writer left room and summoned aid (sic) from another hall to assist- When aid (sic) helped her she stated male aid (sic) could be in her room anytime...."			

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A nurses' note dated 3/6/11 at 9:00 a.m., indicated "...Writer observed (resident) to be tearful this morning. S/S (Social Services) her today et (and) notified of tearfulness...."

During an interview with the Social Services Director (SSD) on 4/15/11 at 11:20 a.m., she indicated she went into the resident's room to introduce herself to her as she was a newly admitted resident. She indicated it was at that time the resident shared with her the concern she had related to LPN #6. She indicated the resident reported the nurse had been harsh in her manner of talking and was loud. The SSD indicated she immediately reported the resident's concern to the DHS and the ED. She indicated the LPN and CNA were suspended pending the investigation. She indicated the LPN's behavior and interaction with the resident was inappropriate. She indicated no staff had reported the resident's concern about LPN #6 to her.

During an interview with the Executive Director on 4/15/11 at 11:45 a.m., she indicated CNA #9 "should have reported the resident was so upset immediately; that is why we counseled him for not reporting."

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	An undated policy and procedure titled "Abuse and neglect procedural guidelines," provided by the ED on 4/11/11 at 9:20 a.m., identified as current indicated "...Trilogy Health Services (THS) has implemented processes in an effort to provide a comfortable and safe environment...Verbal abuse-may include oral, written or gestured language that include disparaging and derogatory terms to the resident/patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability... i. Staff to resident- any episode...Training...provide training for new employees through orientation and with ongoing training programs. Training will include, but is not limited to...identification of abuse or neglect...how to provide protection for residents...how to identify those residents at risk for abusing other residents...how to...report incidents of actual or suspected abuse or neglect...." 3.1-28(c)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their abuse prevention policy and procedure by failing	F0226	CORRECTIVE ACTIONAll employees are educated to the facility's policies and procedures regarding abuse and neglect and	05/15/2011

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	to ensure an incident of verbal abuse, intimidation and harassment between a staff member and a resident was immediately reported and investigated. The alleged staff member worked the remainder of the shift after the incident occurred. This deficient practice affected 1 of 2 abuse allegations reviewed, and 1 discharged resident in a supplemental sample of 1 reviewed for abuse. (Resident #38) Findings include: Review of an abuse allegation provided by the Executive Director on 4/14/11 at 1:10 p.m., indicated the following: A "fax/incident report" dated March 6, 2011 indicated "...Brief description of incident...(Resident #38's name) reported at 10:00 am on 3/6/11 that the night shift nurse (LPN #6) last night yelled at her because (the resident) requested a female staff member to help (the resident) to the BR (bathroom) instead of the male staff member that answered her call light. When the resident asked the nurse (LPN #6) to leave (the resident's) room (the resident) states the nurse did not leave at first and was argumentative... Resident states she does not want this nurse caring for her again...Immediate action taken...the night nurse and male CNA		resident rights at the time of hire in New Employee Orientation. The facility policy requires screening of employees, training of employees, prevention steps and identification steps that include prompt reporting of all resident allegations of abuse. If an allegation is made the first priority is immediate provision of safety for residents that may include moving the resident to another room, providing one-on-one monitoring if appropriate, or suspending the suspected employee(s) pending outcome of investigation. An investigation is immediately initiated as well as prompt reporting to the physician, family member, Triogy management and state agencies. All residents at the time of admission are informed of the facility's zero tolerance for abuse standard and how residents may report any concerns they experience while residing at the campus. The Executive Director and Director of Health Services did take appropriate action immediately when informed of the resident's allegations by suspending the nurse and CNA working on the shift at the time of the incident and initiating an immediate investigation into the resident's allegations. The incident was reported timely to the Indiana State Department of Health. The CNA was counseled and in-serviced on 3-7-11 regarding	

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	(CNA #9) did ask a female CNA to provide care for the resident the remainder of the night shift to alleviate the resident's concern about having a male caregiver. Immediately upon the resident reporting the incident to the Social Services Director (SSD) the SSD contacted the Director of Health Services (DHS) who supervises the nursing staff. The DHS immediately contacted the night nurse (LPN #6) and the male CNA (CNA #9) and they were both placed on suspension pending completion of a full investigation of the incident...Preventative measures taken...The DHS contacted the Executive Director (ED) to apprise her of the resident's concern. The ED contacted the resident's POA/son to make him aware of the resident's concerns, the facility's actions taken to protect the resident and the on-going investigation into the resident's concerns. An in-service on the abuse and neglect policies of the campus was initiated for all staff on 3-6-11...The Social Services Director and ED met with the resident at separate times the afternoon of 3-6-11 and the resident had several visitors and was smiling an interacting with them and showed no signs of distress...." An investigation summary dated March 11, 2011, signed by the ED was provided on 4/14/11 at 4:30 p.m., by the ED and		resident abuse and expressed that he fully understood the need to report immediately any suspected incidents in the future. IDENTIFY OTHER RESIDENTSThe Social Service Director on 3-6-11 did interview all other alert and oriented residents in the health center and asked if they had any concerns with how staff had treated them or with their care. No other residents expressed any mistreatment or concern to the Social Service Director. MEASURES/SYSTEMIC CHANGESEducation for staff was initiated on 3-6-11 for staff from all departments regarding the facility's policies and procedures on abuse and neglect and the importance of any staff member becoming aware of a resident concern to promptly report that to the Executive Director and/or the Director of Health Services so appropriate steps can be taken per facility policy to protect the resident that include suspending the suspected employee(s) pending outcome of investigation. All department staffs will be in-serviced on the abuse and neglect policies and procedures including the requirement to promptly report any allegations.MONITORING CORRECTIVE ACTIONEach month at Resident Council residents are educated regarding their rights including the right to be free from any mistreatment including abuse and neglect and	

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	indicated "...The Social Service Director also interviewed all alert and oriented residents on 3-6-11 on the hallway where the nurse (LPN #6) worked to ensure no other residents were concerned with conduct of staff. No other residents reported any concerns with any staff members...During multiple investigative interviews with the resident at different times and with different individuals this resident was consistent in...recollection of the events that happened early in the morning of 3-6-11. At approximately 12:15 am the resident placed...call light on. The male CNA (CNA #9) on duty entered the room to assist (the resident). When (the resident) realized he was a man, the resident requested that a female CNA assist her as she was uncomfortable with a male caregiver. The male CNA assured the resident that he understood and he left the room and informed his charge nurse. The charge nurse (LPN #6) both acknowledges that the male CNA informed her of the resident's request and both the resident and the charge nurse acknowledge that the charge nurse entered the room alone to talk with the resident. The resident maintains that the charge nurse began talking to her in an inappropriately loud voice, telling the resident that (the resident) needed to allow the male CNA to provide care for (the resident) because he was scheduled		asked if they have any concerns. Any resident allegations of suspected abuse will be immediately investigated and all appropriate and required actions will be implemented including the immediate suspension of the suspected employee(s) pending outcome of the investigation. All investigations are documented and reported immediately to Trilogy division support including outcome of the investigation and action steps taken. Additionally, all allegatons of abuse are reported to the QA committee monthly and the QA committee will review each allegation to ensure the facility policy and procedure was followed. Should negative trends be noted the QA committee will report those findings to Trilogy Division Support for additional training or corrective action.	

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	for that hall to care for the resident and knew how to. The resident indicates that at not time during the conversation did the female charge nurse offer to assist the resident to the bathroom herself The resident states that the charge nurse continued to be argumentative with her about the caregiver status, allowing the conversation to escalate in both tone and content. The resident asked the charge nurse to leave her room and the charge nurse did not immediately comply with that request, causing an increase in the resident's anxiousness. After an additional conversation the charge nurse did leave the room and sought a female caregiver but the resident was distressed and anxious by this point. The charge nurse states in investigative interview that she did offer to take the resident to the bathroom; however the resident remains adamant that she did not. The charge nurse states that she did not yell at the resident but the resident has remained consistent that the nurse did yell at her and was argumentative with her. Investigative interviews were conducted with all staff members working to provide care for the resident on the night shift the event occurred. The male and female CNA's that cared for the resident the night of 3-6-11 also noted in investigative interviews that the resident expressed concern to them about how the charge			

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	nurse talked to her. The charge nurse does acknowledge that she did not leave the resident's room the first time the resident asked. During investigative interviews with the resident, (the resident) clearly recalled how anxious and fearful this conversation made her that evening because of the interaction with the nurse. The resident remained consistent in...praise for the CNA's, stating they were wonderful when they provided care...and ensured (the resident) was cared for the remainder of the night. The resident had no concerns regarding any other staff members or...care other than the charge nurse on duty the early morning of 3-6-11. Based on the results of the investigation, the male CNA received performance counseling and education regarding the importance of him communicating immediately any concerns regarding violation of resident's rights or abuse or neglect and he was allowed to return to work. Based on all the investigative interview, the campus had no alternative but to terminate the nurse based on her failure to honor the resident's rights to have an environment free of harassment and intimidation that provides the resident choice about treatment and care and dignity...." A statement dated March 6, 2011 from CNA #9 indicated "...Resident #38 (name)			

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	put on...call light, CNA #9 answered. (The resident) stated she preferred a female for her privacy. CNA # 9 went to get LPN #6, then CNA #9 went to the bathroom. When CNA #9 came back LPN #6 had already had some sort of confrontation with her, he had not witnessed. Call light 2nd time..Resident #38 (name) grabbed CNA #9's hand and kept holding it, and kept apologizing (sic) to him, she kept saying LPN #6 had been so awful to her, and wouldn't leave the room. Resident #38 (name) said she herself used some unladylike words because LPN #6 (name) wouldn't leave...call light 3rd time...asked to use bedpan...CNA #9 told her he would get (female caregiver)...Resident #38 (name) said no, it was okay for CNA #9 to help her...so CNA #9 (name) helped (Resident #38) on and off bedpan...LPN #6 (name) out at nurse's station...mad, and talked to CNA #9 (name)...'maybe I was raising my voice too loud. Kept focusing on it, over and over, said I feel bad, maybe I was too loud with her'..." Documentation was lacking to indicate CNA #9 immediately reported to facility management the concern the resident shared with him in the early morning of 3/6/11, about LPN #6 having yelled and been awful to the resident.			

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	An "Employee counseling form" dated 3/7/11 for CNA #9 indicated "...Employee was working the night of alleged verbal abuse sustained by Resident #38 (name). Upon notification of suspected verbal abuse, employee was immediately suspended pending investigation. Employee was found to have not been present during alleged verbal abuse altercation between LPN #6 (name) and Resident #38 (name)...Employee has been counseled and inserviced regarding resident abuse and fully understands the need to report immediately any suspected incidents in the future...." Resident #38's record was reviewed on 4/15/11 at 10:20 a.m. The record indicated the resident was admitted to the facility on 4/4/11. The record indicated the resident was her own person and was alert and oriented x 3. A nurses' note signed by LPN #6, dated 3/6/11 at 12:15 a.m., indicated "...Resident put call light on to go to restroom. When male aide entered she did not want him help her (sic)- writer went in room to assist- Attempted to explain that male aide was an employee- Resident became very defensive + belligerent- using foul language- accusing writer of yelling at her + using foul language c (with) her- writer left room			

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and summoned aid (sic) from another hall to assist- When aid (sic) helped her she stated male aid (sic) could be in her room anytime...."

A nurses' note dated 3/6/11 at 9:00 a.m., indicated "...Writer observed (resident) to be tearful this morning. S/S (Social Services) her today et (and) notified of tearfulness...."

During an interview with the Social Services Director (SSD) on 4/15/11 at 11:20 a.m., she indicated she went into the resident's room to introduce herself to her as she was a newly admitted resident. She indicated it was at that time the resident shared with her the concern she had related to LPN #6. She indicated the resident reported the nurse had been harsh in her manner of talking and was loud. The SSD indicated she immediately reported the resident's concern to the DHS and the ED. She indicated the LPN and CNA were suspended pending the investigation. She indicated the LPN's behavior and interaction with the resident was inappropriate. She indicated no staff had reported the resident's concern about LPN #6 to her.

During an interview with the Executive Director on 4/15/11 at 11:45 a.m., she indicated CNA #9 "should have reported

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	the resident was so upset immediately; that is why we counseled him for not reporting." An undated policy and procedure titled "Abuse and neglect procedural guidelines," provided by the ED on 4/11/11 at 9:20 a.m., identified as current indicated "...Trilogy Health Services (THS) has implemented processes in an effort to provide a comfortable and safe environment...Verbal abuse-may include oral, written or gestured language that include disparaging and derogatory terms to the resident/patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability... i. Staff to resident- any episode...Training...provide training for new employees through orientation and with ongoing training programs. Training will include, but is not limited to...identification of abuse or neglect...how to provide protection for residents...how to identify those residents at risk for abusing other residents...how to...report incidents of actual or suspected abuse or neglect...." 3.1-28(a)			

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F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on interview, observation and record review, the facility failed to complete comprehensive assessments for self-administration of medications and a indwelling catheter for 1 of 1 resident who self-administered medications and 1 of 3 residents with indwelling catheters, and failed to ensure comprehensive assessments were accurate related to	F0272	CORRECTIVE ACTION1 - The Elimination Circumstance Assessment had been completed for resident #21 for his in and out catheterization but had not again been completed for the Foley catheter anchored three days later. The resident is currently without a Foley catheter. 2A - A care plan correctly noting the resident's alteration in skin integrity and pressure risk for	05/15/2011

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	pressure ulcers 1 of 1 resident with pressure ulcer assessments in a sample of 10. (Residents #18 and #21). Findings include: 1. Resident #18's clinical record was reviewed on 4/14/11 at 8:35 A.M. The resident was admitted with diagnoses which included, but were not limited to, urinary retention and clostridium difficile. A physician's order dated 3/24/11 indicated "...Foley x (times) 6 days...Dx (diagnosis) retention..." An "Elimination Circumstance, Reassessment and Intervention" form dated 3/25/11 indicated "...in et (and) out cath (catheterization)...approach/intervention update...use toilet (circled)...urinal (circled)..." Documentation was lacking related to the assessment for the Foley catheter. Interview on 4/14/11 at 9:30 A.M. with RN #2 indicated "I think the assessment should have been done." Interview on 4/14/11 at 10:20 A.M. with the Director of Health Services indicated the resident "probably didn't have an assessment for the Foley catheter." She		resident #21 was put in place on 4-12-11. This resident discharged on 4-20-11. 2B - The medications were removed from the room of resident #21 on 4-11-11. IDENTIFY OTHER RESIDENTS1 - Currently no other residents have Foley catheters. Any admissions with a Foley catheter will be assessed during the admission assessment process. 2A - Assessments for all admission/readmissions will be reviewed in the Clinical Meeting Monday through Friday the morning following admission for accuracy of documentation. 2B - All other health center resident's rooms were audited and no other medications were found at the bedside. MEASURES/SYSTEMIC CHANGES1 - Licensed nursing staff will be in-serviced on the need for and proper completion of the Elimination Circumstance form prior to anchoring or removing a Foley catheter. 2A - Assessments for all admission/readmissions will be reviewed in the Clinical Meeting Monday through Friday the morning following admission for accuracy of documentation. 2B - Licensed nursing staff will be in-serviced regarding the importance of observing for any medications at the bedside of the resident. If observed, medications are to be removed and the nurse will evaluate the resident for self-administration of the	

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	indicated an assessment should be completed prior to insertion and after removal of a Foley catheter.		medications. Additionally, an insert is being prepared for the admission packet for residents and family members educating them that residents may not have medications at the bedside without a self-administration assessment being completed. Residents and families will be asked not to bring medications to the resident. If the family brings items for resident use, including over-the-counter items, they will be asked to take the items to the nurses' station first for assessment. MONITORING CORRECTIVE ACTIONDirector of Health Services or designee will monitor daily Monday through Friday at the Clinical Meeting all physician orders related to Foley catheters and will review the Elimination Circumstance Assessment to ensure proper completion. An admission checklist will be utilized to ensure documentation on assessments. A daily audit of the resident room will be completed to ensure that no medications are at the bedside without a self-administration assessment having been completed. Audit results will be reported monthly to the QA committee for three months to evaluate the effectiveness of the measures/systemic changes implemented. If any negative trends are noted the QA committee will recommend changes in interventions and	

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	2 A. The clinical record for Resident # 21 was reviewed on 04/11/2011 at 10:05 a.m. Diagnoses included, but were not limited to, penile cancer with total penectomy, depression, congestive heart failure and history of alcohol abuse. A "PRESSURE/STASIS/ARTERIAL/ DIABETIC ULCER ASSESSMENT," dated 03/29/2011 indicated an area of deep pink discoloration on the sacrum. The assessment indicated a stage 1 pressure ulcer measuring 5 cm (centimeters) long by 3 cm wide with no depth. An "ASSESSMENT REVIEW AND CONSIDERATIONS," dated 03/29/2011, indicated, "...Skin breakdown risk potential: ...None...."		extend the monthly review an additional three months to ensure effectiveness of new interventions.	

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A Minimum Data Set (MDS) assessment, dated 04/05/2011, indicated the resident had one stage 2 pressure ulcer and was at risk for developing pressure ulcers.

During an interview on 04/12/11 at 9:40 a.m., RN # 2 indicated that a resident who was admitted to the facility with a stage 1 pressure ulcer should have been identified at risk for skin break down.

During an interview on 04/15/2011 at 9:15 a.m., the DHS (Director of Health Services) indicated the assessment for skin breakdown on 03/29/2011 was incorrect and should have identified the resident at risk for skin breakdown since he was admitted with a stage 1 pressure ulcer.

2 B. An "ASSESSMENT REVIEW AND CONSIDERATIONS," dated 03/29/2011, indicated, "...Self Medication: ...No plan of care is necessary at this time...."

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A physician's recapitulation, dated 03/29/2011, indicated, "...Ventolin inhale (SIC) Q (every) 4 (symbol for hours) ii (two) puffs (for) wheezing...."

A physician's order, dated 04/01/2011, indicated, "...MOM (Milk of Magnesia) 60 cc (cubic centimeters) po (oral) now & qd (every day) prn (as needed) (for) constipation...."

A MDS assessment dated, 04/05/2011, indicated the resident was cognitively intact.

During observations on 04/11/2011 at 9:30 a.m. and 10:45 a.m., Resident # 21 had one bottle of Milk of Magnesia and one Ventolin inhaler at the bedside. The resident indicated he had used both medications since admission to the facility.

During an interview on 04/11/2011 at 10:45 a.m., RN # 5 indicated

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	medications should not have been at a resident's bedside unless the resident had been assessed for safe self medication administration. During an interview on 04/11/2011 at 10:50 a.m., Clinical Care Coordinator #10 indicated the resident should not have medications stored at the bedside until he had been assessed for safe self medication administration. An undated policy, titled "CLINICAL DOCUMENTATION SYSTEMS Admission Nursing Assessment and Data Collection" was provided by the Executive Director on 04/14/2011 at 1:45 p.m. The policy indicated, "...The assessment shall include identification of risk factors through assessment, observation and review of pertinent documentation that may contribute to additional complications, medical decline or safety concerns...."			

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F0279 SS=D	3.1-31(c)(2) A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to ensure comprehensive care plans were completed related to isolation, a pacemaker, and a gastrostomy tube for 2 of 2 residents with care plans in a sample of 10. (Residents # 23 and #27). Findings include: 1a. Interview on 4/11/11 at 6:50 A.M., during an initial tour, LPN #3 indicated Resident #27 was in respiratory isolation for "MRSA (methicillin resistant staphylococcus aureus [a bacteria]) in her sputum."	F0279	CORRECTIVE ACTION1a - Resident #27 was admitted to the campus on her current stay on 3-30-11. Other admission notes, care plans, and assessments noted in the finding were for prior stays and are not relevant to the current admission. A care plan was updated reflecting the isolation precautions for resident #27 on 4-13-11. This hospice resident expired on 4-22-11. 1b - Resident #27 was admitted to the campus on her current stay on 3-30-11. Other assessments noted in the finding were for prior stays. A care plan was in place for resident #27 related to her	05/15/2011

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	Resident #27's clinical record was reviewed on 4/11/11 at 10:10 A.M. Resident #27 was admitted with diagnoses which included, but were not limited to, pacemaker and recent pneumonia. A hospital admission note dated 3/28/11 indicated "...recent methicillin-resistant Staphylococcus aureus pneumonia." Care plans dated 1/19/11, 3/31/11, 4/1/11, 4/5/11, 4/6/11, and 4/7/11 indicated documentation was lacking related to a care plan to address the resident being in isolation. Interview on 4/12/11 at 9:45 A.M. with LPN #1 indicated the resident should have had a care plan for isolation. Interview on 4/14/11 at 10:20 A.M. with the Director of Health Services indicated isolation should be documented on the care plan. 1b. A nursing admission assessment dated 3/30/11 indicated "...pacemaker (circled)..." Care plans dated 3/31/11, 4/1/11, 4/5/11, 4/6/11, and 4/7/11 indicated documentation was lacking to address the		pacemaker as of 3-30-11 on the Admission Data Collection Assessment form. 2 - Resident #23 was admitted to the campus on 3-31-11. The gastrostomy tube (G-tube) was noted on the admission assessment and noted "do not use though" and the physician did not prescribe any additional orders for interventions as noted on the 3-31-11 nurse's notes. When contacted again regarding any requested interventions the physician on 4-12-11 did order a dry dressing to the peg tube site. A care plan was updated on 4-13-11 and the resident's gastrostomy tube was removed on 4-15-11. IDENTIFY OTHER RESIDENTS1a - All residents' care plans were reviewed to ensure the need for isolation was included in the resident's care plan.1b - All residents' care plans were reviewed for any residents with pacemakers. Care plans are in place and orders are noted. 2 - No other current residents have a gastrostomy tube. If any residents are admitted with a gastrostomy tube the campus will provide care per the care plan developed on physician protocol and orders. MEASURES/SYSTEMIC CHANGES1a - All departments staff will be in-serviced on the policies and procedures for isolation precautions and proper procedures based on the level of	

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	care of the resident having a pacemaker. Interview on 4/12/11 at 9:45 A.M. with LPN #1 indicated the resident should have had a care plan for a pacemaker. 2. Resident #23's clinical record was reviewed on 4/12/11 at 9:50 A.M. The resident was admitted with diagnoses which included, but were not limited to, burns and benign prostatic hypertrophy. A nursing admission assessment dated 3/31/11 indicated "Nutrition...G-tube present..." Care plans dated 3/31/11, 4/1/11, and 4/6/11 indicated documentation was lacking related to a care plan to address the care of the resident having a gastrostomy tube. Interview on 4/12/11 at 11:20 A.M. with LPN #4 indicated the resident should have had a care plan for the gastrostomy tube. Interview on 4/15/11 at 9:10 A.M. with the DHS indicated the admission assessment included the initial care plan but it only indicates what the resident has and not what the care should be. She indicated the care plans were temporary and not complete.		isolation for the resident. 1b - Licensed nursing staff will be in-serviced on the proper completion of the Admission Data Collection Assessment form including pacemakers. 2 - Licensed nursing staff will be in-serviced on the proper completion of the Admission Data Collection Assessment form including gastrostomy tubes. MONITORING CORRECTIVE ACTIONDirector of Health Services or designee will review any residents with isolation precautions, pacemakers and gastrostomy tubes (g-tubes) to ensure appropriate interventions are implemented as part of the ongoing QA process. Audit results will be reported monthly to the QA committee for three months to evaluate the effectiveness of the measures/systemic changes implemented. If any negative trends are noted the QA committee will recommend changes in interventions and extend the monthly review an additional three months to ensure effectiveness of new interventions.	

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F0281 SS=D	3.1-35(a) 3.1-35(b)(1) The services provided or arranged by the facility must meet professional standards of quality. Based on observation, interview and record review, the facility failed to ensure wound care was provided according to professional standards of quality for 1 of 1 residents reviewed for wound dressing changes in a sample of 10 residents (Resident # 21). Findings include: The clinical record for Resident # 21 was reviewed on 04/11/2011 at 10:05 a.m. Diagnoses included, but were not limited to, penile cancer with total penectomy, depression, congestive heart failure and history of alcohol abuse. A physician's recapitulation, dated 03/29/2011, indicated, "...Wet to Dry Drsg (dressing) to (R) (right) groin BID (twice a day)...."	F0281	CORRECTIVE ACTIONThe nurse was immediately instructed on proper technique and acknowledged her error and acknowledged understanding of the proper technique on 4-12-11. IDENTIFY OTHER RESIDENTSAll residents with current dressing orders will be observed during licensed nurse competencies on dressing changes. MEASURES/SYSTEMIC CHANGESLicensed nurses will be in-serviced on dressing changes and infection control practices when performing dressing changes.MONITORING CORRECTIVE ACTIONThe Director of Health Services or designee will observe a randomly selected nurse performing dressing changes three times weekly for four weeks to ensure correct technique (if residents in-house require dressing changes) and then every other week for four weeks and then monthly as part of the ongoing QA process. Any nurse observed not following proper technique during the dressing change will be immediately stopped and instructed on proper procedure and will receive corrective action. Observation	05/15/2011

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	A physician's order, dated 04/11/2011, indicated, "...Clarification: (R) (right) groin drsg (dressing) = (is) pack (with) strips soaked (with) NS (normal saline) - cover (with) coversite. Cut to fit - BID (two times daily)...." RN # 2 was observed providing treatment to Resident # 21's right groin area on 04/12/2011 at 10:00 a.m. Normal saline was poured over 4 inch by 4 inch gauze squares. Sterile Q-tips were used to push the gauze squares into the wound and swab the wound bed. After the wound was cleansed, a moistened gauze strip was packed into the wound by pushing the gauze strip into the wound bed with a sterile Q-tip. The area was covered with coversite (a barrier dressing). There was increased erythema (redness) and tissue separation following the treatment. During an interview on 04/12/2011 at 10:30 a.m., the DHS indicated		results will be reported monthly to the QA committee for three months to evaluate the effectiveness of the measures/systemic changes implemented. If any negative trends are noted the QA committee will recommend changes in interventions and extend the monthly review an additional three months to ensure effectiveness of new interventions.	

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	the physician's order did not include instructions for cleansing the wound using 4 inch by 4 inch gauze squares. She indicated would have expected the RN to use saline flushes to cleanse an incisional wound. During an interview on 04/12 /2011 at 10:40 a.m. RN #2 indicated she always cleaned the wound by pushing the gauze squares into the incision. An undated policy titled, "General Guidelines for Dressing Changes" was provided by the DHS on 04/14/2011 at 2:15 p.m. The policy indicated, "...Follow doctors recommendations for treatment...." Standards for wet to dry dressing changes were verified by: http://woundcentral.com/files/wettodry.pdf, accessed on 04/14/2011 at 9:15 p.m. The procedure indicated, "...Remove soiled dressing...Irrigate wound with normal saline...."			

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	Training verification, titled, "JOB SPECIFIC ORIENTATION CHECKLIST" provided by the Executive Director on 04/15/2011 at 8:30 a.m., indicated RN # 2 received training for wound/dressing changes on 05/06/2010. 3.1-35(g)(1)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure a physician's order was followed related to Vancomycin (an antibiotic) administration for 1 of 1 resident with Vancomycin ordered in a sample of 10. (Resident #18). Findings include: Resident #18's clinical record was reviewed on 4/14/11 at 8:35 A.M. The resident was admitted with diagnoses which included, but were not limited to, chronic obstructive pulmonary disease and clostridium difficile (a bacteria). A physician's fax form dated 4/11/11 indicated "Res (resident) continues on Vanco (vancomycin) 2.5 cc PO (by	F0282	CORRECTIVE ACTIONThis resident had been on Vancomycin since 3-14-11. A physician's order was obtained to discontinue the Vancomycin order. A stool specimen was collected and determined negative for C-diff on 4-21-11. An order was obtained on 4-22-11 to discontinue the isolation procedures. IDENTIFY OTHER RESIDENTSAll current residents physician's orders and Medication Administration Records have been reviewed. MEASURES/SYSTEMIC CHANGESLicensed nursing staff will be in-serviced to review the importance of ensuring a physician's order is obtained and documented for all medication changes. MONITORING CORRECTIVE ACTIONThe Director of Health Services or	05/15/2011

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	mouth) BID (twice a day) for C-Diff (clostridium difficile). Res stools are formed - no odor - Has been on Vanco since March. Do you want stop date..." The physician's response was "D/C (discontinue) 4/24/11." A physician's order dated 4/11/11 indicated "D/C Vanco on 4/24/11." A Medication Administration Record dated April 2011 indicated "3/31/11 Vancomycin 1 Gm (gram) vial. Reconstitute c (with) 20 ml (milliliters) sterile H2O (water) & give 2.5 ml (125 mg [milligrams]) PO BID x (times) 14 days..." Further review indicated the vancomycin had been given from 4/1/11 to 4/10/11. A notation indicated "D/C 4/11/11." Documentation was lacking related to the vancomycin having been given after 4/10/11. Interview on 4/14/11 at 9:30 A.M. with RN #2 indicated the vancomycin had been discontinued and had not been given after 4/10/11. 3.1-35(g)(2)		designee will monitor physician orders Monday through Friday at the Clinical Meeting to ensure physician orders are followed to ensure that antibiotic orders have been properly entered on the Medication Administration Record. If the Director of Health Services observes that orders have not been properly documented the nurse failing to follow policy and procedure will receive corrective action. The Director of Health Services will report findings to the QA committee monthly for three months. The QA committee will review and if negative trends are noted the QA committee will recommend changes in interventions and extend the monthly review an additional three months to ensure effectiveness of new interventions.	

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a resident received necessary care and services related to pacemaker parameters and information for 1 of 1 resident with a pacemaker in a sample of 10. (Resident #27). Findings include: Resident #27's clinical record was reviewed on 4/11/11 at 10:10 A.M. The resident was admitted with diagnoses which included, but were not limited to, pacemaker and non-ischemic arteriosclerotic heart disease. A hospital discharge summary dated 3/30/11 indicated "...pacemaker wire in the right ventricle...final diagnoses:...pacemaker..." Review of a physician's recapitulation dated April 2011 indicated documentation was lacking related to pulse parameters for notifying the physician. Review of the clinical record indicated there was no information available related to the type of pacemaker or upper and	F0309	CORRECTIVE ACTIONResident #27 was admitted to the campus on her current stay on 3-30-11 and the resident was admitted to hospice care on 4-7-11. A care plan was in place related to her pacemaker as of 3-30-11 on the Admission Data Collection Assessment form. Per investigation of prior medical records the resident had a pacemaker check every four months and the next check was due in the month of April. When advised of the physician's previous order for a pacemaker check in April, the resident's responsible party requested that no further pacemaker checks be conducted due to the resident's hospice status and a physician's order was obtained to discontinue pacemaker checks. The resident expired on 4-22-11. IDENTIFY OTHER RESIDENTSAll residents care plans were reviewed for any residents with pacemakers. Care plans are in place and orders are noted per physician order. MEASURES/SYSTEMIC CHANGESLicensed nursing staff will be in-serviced regarding the policy and procedures for completion of the Admission Data Collection Assessment form including pacemakers and	05/15/2011

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	lower pulse rate limits of the pacemaker. Interview on 4/12/11 at 9:45 A.M. with LPN #1 indicated she was unaware of what type of pacemaker the resident had or what pulse limits were set for the pacemaker. She stated "55 or 60 or above 110?" Interview on 4/12/11 at 11:55 A.M. with the MDS coordinator indicated the facility did not have a policy related to caring for a resident with a pacemaker. Review of Lippincott's Nursing Procedures, Fifth Edition, 2009 indicated the pulse should be checked for one minute daily and the pacemaker instruction booklet and pacemaker identification card should be available at all times. 3.1-37(a)		properly noting physician orders. MONITORING CORRECTIVE ACTIONDirector of Health Services or designee will review any residents with pacemakers to ensure appropriate interventions are implemented. If the Director of Health Services observes that a nurse is not following the policy and procedure by ensuring a care plan is in place and orders are noted per physician order the nurse will receive corrective action. The Director of Health Services will report findings to the QA committee monthly for three months. The QA committee will review and if negative trends are noted the QA committee will recommend changes in interventions and extend the monthly review an additional three months to ensure effectiveness of new interventions.	

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F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to provide interventions to prevent pressure ulcers and failed to provide the appropriate treatment for pressure ulcers resulting in development of two Stage II pressure ulcers for 1 of 5 residents with pressure ulcers in a sample of 10. (Resident #27). Findings include: On 4/11/11 at 6:50 A.M., during an initial tour with LPN #1, Resident #27 was identified as having an "open area" on her coccyx and left buttock, being incontinent, and being on hospice. The resident was on a pressure reducing mattress lying on her back. On 4/11/11 at 9:25 A.M., Resident #27 was observed in bed lying on her back. On 4/12/11 at 8:55 A.M. with LPN #1, Resident #27 was observed in bed lying	F0314	CORRECTIVE ACTIONResident #27 was admitted on her current stay on 3-30-11. All other assessments, care plans and documents dated prior to that date as noted in the finding are not relevant to the current stay. On the resident's admission assessment and care plan dated 3-30-11 under the Skin Plan of Care the following interventions were implemented: turn and reposition for comfort and with care; prevent skin from touching skin; elevate heels off surface; use lift sheet to reposition in bed; provide pressure relieving device to bed; ensure resident is clean and dry; provide padding for casts, splints, etc; ensure adequate hydration; observe labs; observe nutritional intake; provide vitamins and supplement per physician order; check edema, circulation for cast and splints. Due to the resident's health status and prognosis the resident's family elected hospice services for the resident on 4-7-11. The hospice nurse and Director of Health Services both noted on 4-8-11 that a change in	05/15/2011

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	on her back. The resident was assisted to turn to her side. There was a wound observed on her coccyx and on her left buttock. There was a white substance over the wounds. There was no dressing in place. LPN #1 measured the wounds as follows: Coccyx - 0.9 by 0.6 cm. LPN #1 indicated it was "just an open area. Excoriation." Left buttock - 1.4 by 1.2 cm. LPN #1 indicated it was "an open area from rubbing and moisture. It doesn't look like pressure." LPN #1 applied Calazime cream (a moisture barrier cream) to both wounds. There was no dressing applied. A label on the tube of Calazime indicated "skin protectant paste with zinc oxide...uses helps prevent diaper rash...external use only...do not use on deep or puncture wounds..." Resident #27's clinical record was reviewed on 4/11/11 at 10:10 A.M. The resident was admitted with diagnoses which included, but were not limited to, cerebrovascular accident, urinary incontinence, recent pneumonia, spinal stenosis, right parietal infarct, and osteoporosis.		the resident's pressure reducing mattress was delayed due to the resident's significant pain with mobility that was charted. The nursing staff did turn and reposition the resident per the plan of care. The facility policy provided in the survey indicated that turning and repositioning is not routinely documented as this is a normal nursing standard of practice that will be performed in accordance with the resident's care plan. The Calazime cream was an appropriate treatment for the resident's partial thickness pressure ulcers that were less than 0.1 cm and were not deep or puncture wounds. The staff had selected a cream treatment rather an occlusive dressing due to the son's reporting that the resident had a history of sensitivity to adhesives. Calazime is a zinc based barrier cream. IDENTIFY OTHER RESIDENTSCurrent residents with pressure areas were reviewed and treatments and care plans were appropriate for the pressure areas. MEASURES/SYSTEMIC CHANGESLicensed nursing staff will be in-serviced on the prevention of pressure areas and appropriate treatment of pressure areas. MONITORING CORRECTIVE ACTIONDirector of Health Services or designee will monitor interventions and treatments of residents with pressure areas three times weekly for four weeks and then	

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	An admission minimum data set (MDS) assessment dated 1/7/11 indicated the resident was cognitively intact, required limited one-person physical assistance for bed mobility, transfer, and toilet use, was continent of bowel and bladder, was at risk for developing pressure ulcers, had no pressure ulcers, had pressure reducing devices for bed and chair, and was not on a turning and repositioning program. An MDS reentry assessment dated 3/4/11 indicated the resident was cognitively intact, required supervision of one person for bed mobility and transfer, required limited assistance of one-person for toilet use, was occasionally incontinent of urine, continent of bowel, was at risk for developing pressure ulcers, had no pressure ulcers, had a pressure reducing device for the bed, was not on a turning and repositioning program. A nursing admission assessment dated 3/30/11 indicated the resident had short-term memory deficits and illogical flow of speech, was always incontinent, had a pressure reducing device to bed (indicated by checkmark), skin was exposed to moisture, was unable to change positions, and had a history of skin impairment. Further review indicated "...skin plan of care...turn and reposition for comfort and with care (indicated by		every week for four weeks and then monthly as part of the ongoing QA process. All skin issues including pressure ulcers are reported to Trilogy Clinical Support each week by the Director of Health Services and the trends are monitored and action steps implemented if negative trends are observed. Each month the QA committee reviews Skin Care Management for residents including pressure ulcers and also monitors for negative trends and if those are observed will work in conjunction with Trilogy Clinical Support to implement interventions.	

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	checkmark)...use lift sheet to reposition in bed...provide pressure relieving device to bed (circled)..." A resident care plan dated 1/19/11 and updated 3/31/11 indicated "Potetential (sic) Alteration in Skin Integrity related to: immobility ...other: recent surgery, orif (open reduction internal fixation) of left lower leg for fractured fibula and a fractured rib...interventions: examine skin daily for signs of redness, discoloration...encourage and assist to turn and reposition q2hrs (every two hours) and prn (as needed). Avoid shearing...pressure reducing mattress on bed...pressure reducing cushion to chair...weekly skin assessment by licensed nurse..." A nurses' note dated 4/10/11 at 2:00 P.M. indicated "noted open areas on bilt (bilateral) coccyx area. Area on (R) (right) upper coccyx measures 1 cm (centimeter) x 1 cm et (and) (L) (left) coccyx 2.5 x 2 cm. Hospice called et will need re-called in AM. No non emergency messages able to get nurse. Son (name) notified. Res (resident) T/R (turned/repositioned) q20 (every two hours)." Nurses' notes 3/30/11 through 4/10/11 indicated documentation was lacking related to the resident having been turned and repositioned.			

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	Skin tracking sheets indicated: Left buttock: 4/10/11 "Other Skin Impairment Assessment...Stage II..Present on admission N (circled)...location: (L) buttock...Length 1.5 Width 1.2 Depth < (less than) 0.1...Brown/p (pink)...Tx (treatment) Calmo...See pressure ulcer sheet. 4/12/11 "Pressure/Stasis/Arterial /Diabetic Ulcer Assessment...Highest stage II...L (length) 1.5 W (width) 1.2 D (depth) < 0.1...Color/tissue type/percent/location: pale pink...current treatment Calazine (barrier cream)...Current preventative interventions: T (turn) et R (reposition) as tol (tolerated)..." Coccyx: 4/10/11 "Other Skin Impairment Assessment...Stage II..Present on admission N (circled)...location: (R) coccyx/sacrum...Length 1 cm Width 1 cm Depth < (less than) 0.1...R (red)...Tx (treatment) Calmo...See purple pressure ulcer sheet. 4/12/11 "Pressure/Stasis/Arterial /Diabetic Ulcer Assessment...Highest stage II...L (length) 1 W (width) 1 D (depth) <			

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	0.1...Color/tissue type/percent/location: pale pink...current treatment Calazine (barrier cream)...Current preventative interventions: T (turn) et R (reposition) as tol (tolerated)..." A physician's order dated 4/11/11 indicated "Calazime Crm (cream). Apply to bil (bilateral) buttock sacral area TID (three times a day) et PRN p (after) ea (each) incontinent episode..." A Treatment Administration Record dated April 2011 indicated the Calazime cream had not been applied as ordered on the 10-6 shift on 4/11/11. Further review indicated weekly skin checks had been completed on 4/2/11 and 4/9/11 but there was no documentation related to the condition of the skin. A CNA Assignment sheet dated 4/13/11, provided by Clinical Care Coordinator #10, and identified as current, indicated documentation was lacking related to turning and repositioning the resident every two hours. Interview on 4/12/11 at 8:55 A.M. with LPN #1 indicated the Calazime cream was being used every two hours on the resident's pressure ulcers. Interview on 4/12/11 at 9:45 A.M. with			

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	LPN #1 indicated the resident was being turned and repositioned every 2 hours but there was no documentation. She indicated there were no barrier creams being used prior to the resident developing the pressure ulcers. Interview on 4/12/11 at 9:45 A.M. with the MDS coordinator indicated the Calazime cream was being used on the pressure ulcers because the family said the resident was allergic to tape. Review on 4/13/11 at 12:00 P.M. of an undated facility policy and procedure provided by the administrator and titled "Wound Risk Assessment Guideline" indicated "All skilled residents shall have a daily system assessment review that shall identify a change in the risk factors impacting skin integrity..." Review on 4/13/11 at 12:00 P.M. of a facility policy and procedure dated 1/06 and revised 4/08 provided by the administrator and titled "Weekly Skin Assessment Guideline" indicated "Upon admission the admitting nurse shall include as part of the admission orders weekly skin assessment. The order shall read: 'Weekly skin assessment on (day of the week). 0=no areas of skin impairment. 1=new area of impairment (see wound sheet). 2=existing area of impairment (see			

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	wound sheet)...The nurse completing the weekly skin check shall indicate the appropriate number (0, 1, 2) and their initials..." Review on 4/13/11 at 12:00 P.M. of a facility policy and procedure dated 10/07 provided by the administrator and titled "Turning and Repositioning" indicated "Turning and repositioning is not routinely documented...Exceptions to this practice will be noted if the resident is on a dedicated turning and repositioning program..." Review on 4/13/11 at 12:00 P.M. of an undated facility policy and procedure provided by the administrator and titled "Basic Wound Interventions" indicated "...Basic wound treatment:...Maintain moist wound bed. Cover and protect..." 3.1-40(a)(1) 3.1-40(a)(2)			
F0365 SS=D	Each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, record review, and interview, the facility failed to ensure a resident received a mechanically altered diet as ordered by the physician. This deficient practice effected 1 of 2 residents reviewed for therapeutic diets in a sample	F0365	CORRECTIVE ACTIONWhen the Director of Health Services was made aware of the resident receiving the incorrect diet the food was removed and replaced with the correct food texture. On 4-12-11 the resident's diet tray card was corrected immediately	05/15/2011

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	of 10. (Resident #13) Findings include: During an observation on 4/11/11 at 10:02 a.m., Resident #13 was observed in bed with a meal tray on his bedside table. The meal consisted of an egg omelet with ham, 2 pieces of toast, and a sausage patty. The meat on the tray was not ground. During an observation on 4/12/11 at 12:15 p.m., Resident #13 was observed in the dining room. The resident was served his meal tray. The meal consisted of a hamburger patty on a bun with lettuce and tomato, french fries, and a bowl of pineapple chunks. During an interview with the Director of Health Services (DHS), on 4/12/11 at 12:30 a.m., she indicated Resident #13's diet was to be mechanical soft, ground meat with thin liquids. She indicated "that is not a mechanical soft tray." During an interview with Chef #1 on 4/12/11 at 12:35 p.m., he indicated the only way he would have of identifying a resident's diet when serving the meal would be to look at the tray card. He indicated he was not aware the resident had an order for a mechanical soft diet		when the Director of Food Services became aware to reflect the proper diet of mechanical soft with ground meat and thin liquids. On 4-12-11 an in-service was held with nursing staff to ensure staff knew how to review diet orders when serving resident meals to ensure the diet served is correct. Dining Services staff were also in-serviced on 4-12-11 regarding the importance of reviewing the tray card when chefs are plating the meal to ensure all foods served are in accordance with the diet order. IDENTIFY OTHER RESIDENTSAn audit was conducted on 4-12-11 of all resident diets by the Director of Food Services. All other resident diets were entered into the diet tray card correctly and matched the physician's order. MEASURES/SYSTEMIC CHANGESNursing staff will be in-serviced on the tray card system and proper observation of the resident's plated meal and ensuring it matches the resident's diet order. The Director of Food Service implemented a change in communication with the Therapy Department regarding diet change orders initiated by speech therapy. Therapy is now providing a copy of diet order changes to both nursing and dining services and the Director of Food Services is confirming with nurses the physician's order for diet when confirmed by the attending	

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	with ground meat. He indicated he served the diet that was indicated on the tray card. He indicated the resident had not been receiving a mechanical soft diet and he did not know how the tray card and the resident's ordered diet could be so far off. Resident #13's record was reviewed on 4/11/11 at 10:40 a.m. Diagnoses for Resident #13 included, but were not limited to, diabetes mellitus, dementia, CVA (stroke), and a history of dysphagia. The record indicated the resident was re-admitted to the facility on 2/25/11 with a 2000 cal (calorie) cardiac ADA (diabetic) mech (mechanical soft) ground meat et (and) thin liquids. A physician's order dated 2/28/11 indicated "...diet-mechanical soft, ground meat et (and) thin liquids...." A physician's orders recapitulation for April, 2011 indicated Resident #13's diet was "...mechanical soft, ground meat & thin liquids...." A meal tray card for Resident #13 dated 4/12/11, indicated the resident's diet was a CCHO (consistent carbohydrate), NAS (no added salt). An undated "Dietary communication" form provided by the DHS on 4/12/11 at		physician. The Consultant Dietitian will audit each new resident's diet when completing the comprehensive assessment to ensure the diet order and tray card match. MONITORING CORRECTIVE ACTIONAn audit of diet orders and tray cards will be completed each month for 3 months to ensure diet orders and tray cards match. The audit results will be reported to the QA Committee each month. The QA committee will review and if negative trends are noted the QA committee will recommend changes in interventions and extend the monthly review an additional three months to ensure effectiveness of new interventions.	

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	12:45 p.m., indicated "...diet order: 2000 cal (calorie) cardiac...comments (located in the right hand corner of the form): Mechanical soft, ground meat thin liquids..." During an interview with the DHS at the time the dietary communication form was provided, she indicated the form was provided to the Dietary Manager by the nursing staff, to ensure the resident received the diet ordered by the physician. During an interview with the Dietary Manager on 4/12/11 at 1:45 p.m., he indicated he received a copy of the dietary communication form from the nursing staff. He indicated the ordered diet was usually written on the diet order line of the communication form. He indicated the mechanical soft ground meat was written on the comment line. He indicated he must have "just missed it." He indicated the resident had been receiving a consistent carbohydrate, no added salt diet prior to today. A policy and procedure, dated 2009, titled "Sequence of meals/ trays and tray cards" provided by the Dietary Manager on 4/14/11 at 2:45 p.m., identified as current indicated "...Meals will be efficiently and accurately distributed to individuals...each individual will have a tray card that			

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	includes the individual's name, room number, diet order...tray cards will be followed to ensure the correct diet is served...dining services staff will maintain and print up-to-date tray cards...." A policy and procedure, dated 2009, titled "Diet orders-general information" provided by the Executive Director on 4/15/11 at 8:40 a.m., identified as current indicated "...Diets will be ordered by the physician..."			
F0371 SS=F	3.1-21(a)(3) The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure foods were stored and prepared in a sanitary manor related to improper storage of frozen food and lack of hand washing and changing gloves when contaminated. This deficient practice had the potential to affect 36 of 36 residents served from the kitchen. Findings include:	F0371	CORRECTIVE ACTIONOn 4-11-11 the food on the floor in the walk-in freezer was immediately placed on the shelves in the freezer. The Director of Food Services reviewed the policy and procedure for proper storage of food with the kitchen staff including chefs and dining services assistants on 4-11-11. The surveyor observation of Chef #1 occurred on 4-12-11 not 4-13-11 as noted in the finding. The Director of Food Services on 4-12-11 informed Chef #1 and #2 of the surveyor's observations and concerns with glove changing and hand washing. The kitchen	05/15/2011

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	During the initial kitchen tour on 04/11/2011 at 6:55 a.m., two boxes of vegetables, two boxes of beef patties, and four boxes of chicken were stored on the floor of the walk in freezer. During an interview on 04/11/2011 at 7:00 a.m., the dietary manager indicated the food had been delivered to the facility on 04/09/2011. He indicated he did not work on the week end when the food was delivered, but the food should not have been stored on the freezer floor. Observations of food preparation began on 04/13/2011 at 11:30 a.m. During the observation period, Chef # 1 was observed touching a box of Angus beef and plastic food wrap with gloved hands. He opened a bulk package of cheese and removed a stack of cheese slices. He then opened the box of beef. He walked over to the fryer and touched the handle of the fryer		staff were immediately insructed on proper technique and acknowledged an understanding of the proper technique for hand washing policy and glove use. IDENTIFY OTHER RESIDENTSCorrective actions noted apply to all residents of the health center.MEASURES/SYSTEMIC CHANGESAn audit tool is being created and implemented for audits of food storage areas to be completed weekly by the Director of Food Services or designee. Dining Services staff will be in-serviced by Division Dining Support regarding food storage and glove and hand washing use. MONITORING CORRECTIVE ACTIONAudits of food storage will be completed weekly for 3 months and then monthly as part of the ongoing QA process. The Consultant Dietitian will audit meal preparation/plating once every week for four weeks and then once every two weeks for eight weeks and then once every month for three months as part of the QA process. The QA committee will review and if negative trends are noted the QA committee will recommend changes in interventions and extend the monthly review an additional three months to ensure effectiveness of new interventions.	

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	basket. He returned to the grill and began frying hamburgers. A few minutes later he removed French fries from the fryer and took them to the serving counter. He touched the fries and obtained a food temperature. He recorded the temperature in the log book, then opened a box of hamburgers and placed the patties on the grill. After the patties were placed on the grill, he removed his gloves and washed his hands. This was the first observation of washing hands and changing gloves after multiple times of contamination. Chef # 2 was observed removing lettuce and tomatoes from the refrigerator with gloved hands. He placed the food on the counter, then obtained trays and plates. He returned to the food prep area and placed lettuce and tomatoes onto buns without washing his hands or changing gloves. The Dietary Manager was observed touching multiple surfaces with his			

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	155777	A. BUILDING 00 B. WING	04/15/2011

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	gloved hands. The surfaces included refrigerator doors, the food prep counter, bowls, a knife and a package of cheese slices. He reached into his pants pocket, then picked up the knife and opened the cheese package. He did not change gloves or wash hands between touching surfaces and touching food. During an interview on 04/12/2011 at 11:52 a.m., the Dietary Manager indicated all staff should wash their hands and change gloves between touching surfaces and food and before and after touching raw and ready-to-eat foods. An undated policy, titled, "Storage Procedures" was provided by the Dietary Manager on 04/14/2011 at 2:30 p.m. The policy indicated, "...Meat, fish, and poultry are stored on lower shelves below fruits, vegetables, juices, and breads to prevent contamination...." An undated policy, titled,			

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	"Importance of Hand washing" was provided by the Executive Director on 04/13/2011 at 12:00 p.m. The policy indicated, "...You must wash your hands and put on clean gloves after any of the following activities: ...After hand contact with unclean equipment and work surfaces...Before and after handling raw foods. Before and after handling ready to eat foods...." 3.1-21(i)(3)			

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to ensure isolation standards were maintained for residents with infectious diseases and failed to ensure appropriate handwashing	F0441	CORRECTIVE ACTION1 - Resident #27 was admitted on her current stay on 3/30/11. All other assessments and care plans noted in the finding are not relevant to the current stay and	05/15/2011

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	and disinfection of scissors during a dressing change. These deficient practices affected 2 of 2 residents in isolation, and 1 of 2 residents observed during dressing changes in a sample of 10 residents reviewed for infection control. (Residents #18, #21, and #27). Findings include: 1. On 4/11/11 at 6:50 A.M., during an initial tour with LPN #3, Resident #27 was identified as being in isolation for "MRSA (methicillin-resistant staphylococcus aureus) in her sputum." There was a sign on the door which indicated "Please see the nurse before entering" and red barrels sitting in the bathroom. The door was open. On 4/11/11 at 9:25 A.M., Resident #27 was observed lying in bed in her room. There was a visitor in the room. He did not have a mask on. Interview on 4/11/11 at 11:15 A.M. with CNA #6 indicated the resident was in "respiratory isolation" and staff should wear a mask and gown in the room. Interview on 4/12/11 at 8:55 A.M. with LPN #1 indicated "they had found something in her lungs. MRSA. The isolation is just for safety precautions.		resident #27 was not in isolation on prior stays. The Clinical Care Coordinator and Hospice nurse did meet with the resident's family on 4-14-11 and educated them about isolation procedures and personal protective equipment. The nurse observed leaving the resident's room with a mask on was educated regarding proper isolation technique and to remove the mask and wash hands before leaving the resident's room. Hospice resident #27 did expire on 4-22-11.2 - The therapy staff member was instructed on the proper precautions to take when entering resident rooms of residents with isolation precautions in place. 3 - Regarding infection control for resident #21 during the dressing change, the nurse was immediately instructed on proper technique and acknowledged her error and acknowledged an understanding of the proper technique for infection control. IDENTIFY OTHER RESIDENTSIsolation procedures were reviewed for all residents in isolation and proper procedures were in place. MEASURES/SYSTEMIC CHANGESAll department staffs including therapy will be in-serviced on the policies and procedures for isolation and infection control including hand washing. Licensed nurses will be in-serviced on the proper	

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	You just have to wear a mask for respiratory." On 4/12/11 at 9:10 A.M., LPN #1 was observed leaving Resident #27's room. She had a mask in her hands and carried it down the hall and disposed of it in the med cart trash. She was not observed to wash her hands after leaving the room. Resident #27's clinical record was reviewed on 4/11/11 at 10:10 A.M. The resident was admitted with diagnoses which included, but were not limited to, cerebrovascular accident, recent pneumonia, and left parietal infarct. A hospital discharge summary dated 3/30/11 indicated "...recent methicillin-resistant Staphylococcus aureus pneumonia." A Nursing Admission Assessment dated 3/30/11 indicated the resident had short-term memory deficits and "Infectious Diseases...MRSA N (no [circled])." There was no documentation related to a care plan to address the resident having respiratory MRSA or being in isolation. A Minimum Data Set Admission Assessment dated 1/7/11 indicated the resident was cognitively intact and was		disinfecting of scissors during dressing changes. MONITORING CORRECTIVE ACTIONDirector of Health Services or designee will review any residents with isolation precautions to ensure appropriate interventions are implemented; will observe a randomly selected nurse performing dressing changes three times weekly for four weeks to ensure correct technique (if residents in-house require dressing changes) and then every other week for four weeks and then monthly; and will observe hand washing technique in randomly selected employees in each department two times weekly for four weeks and then one time weekly for four weeks and then monthly as part of the ongoing QA process. The QA committee will review audit and observation reports and if negative trends are noted the QA committee will recommend changes in interventions. The effectiveness of those interventions will be assessed at the following monthly meeting to ensure the facility's policy and procedure for isolation and infection control is followed.	

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	not in "isolation or quarantine for active infectious disease. A resident care plan dated 1/19/11, 3/31/11, 4/1/11, 4/5/11, 4/6/11, and 4/7/11 indicated documentation was lacking related to a care plan to address the resident's MRSA and isolation. A nurses' note dated 3/31/11 at 12:30 P.M. indicated Met c (with) (resident name) son's...they discussed the isolation precautions due to respiratory MRSA...They also stated, 'no one seemed concerned because they quit gowning up and only used gloves' referring to hospital staff. Resident is not currently on antibiotics..." A physician's order dated 4/13/11, after surveyor intervention, indicated "Cont (continue) dropplet (sic) precautions. Obtain sputum culture if res (resident) produces sputum." Interview on 4/14/11 at 10:20 A.M. with the Director of Health Services (DHS) indicated the clinical care coordinator monitors and provides education to staff. She indicated families should be educated regarding isolation. She indicated the resident had respiratory MRSA and the isolation was "precautionary."			

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	2. On 4/11/11 at 6:50 A.M., during an initial tour with LPN #3, Resident #18 was identified as being in isolation for C-Diff (clostridium difficile [a bacteria]). The door was open. There was a sign on the door indicating "Please see the Nurse before entering." There were red barrels in the bathroom. On 4/13/11 at 10:15 A.M. PT #7 was observed standing in Resident #18's room. The therapist was leaning against the bed with her hands resting on the footboard. She did not have gloves on. She did not wash her hands after she left the room. The resident's wife was also in the room and was not wearing gloves. Resident #18's clinical record was reviewed on 4/14/11 at 8:35 A.M. The resident was admitted with diagnoses which included, but were not limited to, C-Diff. A hospital history and physical dated 2/16/11 indicated "recent Clostridium difficile colitis, and we will continue his oral vancomycin (an antibiotic) here..." A Minimum Data Set Assessment dated 2/26/11 indicated the resident was moderately impaired in cognitive skills, required extensive two-person physical assist for transfer, required extensive			

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	one-person physical assist for toilet use and personal hygiene, and was not in "isolation or quarantine for active infectious disease..." A Minimum Data Set Assessment dated 3/26/11 indicated the resident was moderately impaired in cognitive skills, required extensive one-person physical assist for transfer and personal hygiene, required extensive two-person physical assist for toilet use, and was not in "isolation or quarantine for active infectious disease..." A resident care plan dated 2/2/11 indicated "...C-Diff infection...follow standard precaution protocols...follow other appropriate precautions...contact (indicated by x)...provide resident/family education..." An "Infection Assessment and Review" dated 3/16/11 indicated "...contact isolation..." A laboratory report dated 3/16/11 indicated "C-Diff toxin Positive...C-Diff antigen Positive..." Interview on 4/12/11 at 10:35 A.M. with CNA #8 indicated the resident was in isolation for C-Diff and gloves should be worn when entering the room but no mask			

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	or gown. Interview on 4/14/11 at 9:30 A.M. with RN #2 indicated if there was physical contact with the resident a gown and gloves should be worn. She indicated staff should wash their hands before leaving the room. Interview on 4/14/11 at 10:20 A.M. with the DHS indicated families should be educated related to the isolation. Interview on 4/14/11 at 11:47 A.M. with the DHS indicated the staff was verbally instructed staff regarding isolation but there was no documentation. She indicated hospice educated the family but it was the facility's responsibility to educate the families and staff. Review on 4/12/11 at 11:55 A.M. of an undated facility policy and procedure provided by the MDS coordinator and titled "Droplet Precautions" indicated "...when entering room, all staff should wear a surgical mask...update care plan..." Review on 4/12/11 at 11:28 A.M. of an undated facility policy and procedure provided by the Payroll clerk #9 and titled "Contact Precautions" indicated "...Wear latex gloves when entering the room before contact with the resident or			

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	environmental objects. Change gloves and wash hands after direct contact with the resident, possible infective material, or potentially contaminated environmental objects and between each resident care intervention....visitors must be taught how to properly gown, glove, and should be given educational information on contact precautions...update the care plan..." 3. The clinical record for Resident # 21 was reviewed on 04/11/2011 at 10:05 a.m. Diagnoses included, but were not limited to, penile cancer with total penectomy, depression, congestive heart failure and history of alcohol abuse. A physician's recapitulation, dated 03/29/2011, indicated, "...Wet to Dry Drsg (dressing) to (R) (right) groin BID (twice a day)...." A physician's order, dated 04/11/2011, indicated, "...Clarification: (R) (right) groin drsg (dressing) = (is) pack (with) strips soaked (with) NS (normal saline) - cover (with) coversite. Cut			

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	to fit - BID (two times daily)...." RN # 2 was observed providing treatment to Resident # 21's right groin area on 04/12/2011 at 10:00 a.m. The RN changed her gloves after removing the old dressing, but then reached into her pocket to retrieve a pen. She resumed wound treatment without changing her gloves or washing her hands. The saline gauze strips used to pack the wound were cut with scissors that had not been cleaned prior to use. During an interview on 04/12/2011 at 10:30 a.m., the DHS (Director of Health Services) indicated the nurse should have changed her gloves after reaching into her pocket. She indicated the scissors should have been sanitized prior to use. During an interview on 04/12/2011 at 10:40 a.m., RN # 2 indicated she should have changed her gloves after reaching into her pocket. She indicated the scissors should have been cleaned before use.			

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	An undated policy, titled, "General Guidelines for Dressing Changes" was provided by the DHS on 04/14/2011 at 2:15 p.m. The policy indicated, "...Wash hands with soap and water...Put on second pair of disposable gloves...If using scissors, make sure it is clean (SIC) with antiseptic after contact with soiled dressings...." 3.1-18(b)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure clinical records were complete and accurate related to medication and dietary supplement administration. This deficient practice effected 2 of 10 residents reviewed for complete and accurate clinical records in a sample of 10. (Resident #13 and #24)	F0514	CORRECTIVE ACTION1A - The physician for resident #13 was contacted regarding clarification on the Metoprolol parameters and on 4-14-11 ordered "Metoprolol parameters - hold for systolic BP<110 and pulse <60". 1B - The supplement order for resident #13 was evaluated and a required notation for percentage (%) of supplement consumed was	05/15/2011

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	Findings include: 1 A. Resident #13's record was reviewed on 4/11/11 at 10:40 a.m. Diagnoses for Resident #13 included, but were not limited to, diabetes mellitus, dementia, congestive heart failure, chronic atrial fibrillation, hypertension, CVA (stroke), severe peripheral vascular disease, amputation of the left great toe, and peripheral neuropathy. The record indicated the resident had multiple diabetic ulcers on his feet. Medication administration records (MAR) dated 4/1/11 through 4/11/11 indicated the resident received "...metoprolol (blood pressure medication) 50 mg (milligrams) give 1 tablet by mouth twice a day for HTN (hypertension)..." Hand written on the MAR was a statement that indicated "...hold SBP (systolic blood pressure) > (greater than) 110: HR (heart rate) > 60...." Documentation related to hold parameters was incorrect. During an interview with LPN #4 on 4/13/11 at 10:28 a.m., she indicated the hold parameters on the medication were incorrect. She indicated the hold parameters should have been hold for SBP < 110 and heart rate < 60. During an interview with the Clinical		added to the Medication Administration Record. This resident discharged home on 4-25-11.2A, 2B and 2C - An investigation was initiated regarding the medications not documented as administered. The medications were given to the resident but documentation of administration had not been properly completed. Education and counseling was provided for the nurses not properly documenting medication administration. IDENTIFY OTHER RESIDENTSAll health center residents with supplement orders were evaluated and a required notation for percentage (%) of supplement consumed was added to each resident's Medication Administration Record. All current residents' Medication Administration Records have been reviewed and if documentation of medication administration was found lacking, investigation, education and counseling is being provided for the affected nurses. MEASURES/SYSTEM CHANGESLicensed nursing staff will be in-serviced to document the percentage (%) of supplement consumed for all supplement orders for residents. MONITORING CORRECTIVE ACTIONDirector of Health Services or designee will review all physician orders at the Clinical Meeting Monday through Friday	

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	Care Coordinator #11 on 4/13/11 at 10:35 a.m., she indicated the hold parameters for the metoprolol were incorrect. During an interview with the Director of Health Services (DHS) on 4/13/11 at 3:30 p.m., she indicated the hold parameters for the metoprolol were incorrect as you would hold the medication if the SBP was less than 110 or the heart rate was less than 60. She indicated the facility was unable to find a physicians order to identify where the hold parameters came from. 1 B. The clinical record indicated Resident #13 was admitted to the facility with numerous diabetic ulcers to his feet. To aide in healing of the diabetic ulcers the resident received a dietary supplement. MAR dated 4/1/11 through 4/11/11 indicated the resident received "...Juven- 1 packet 2 X/ day...." Documentation was lacking to indicate the amount of the supplement the resident consumed. During an interview with LPN #4 on 4/13/11 at 10:28 a.m., she indicated the amount of Juven the resident drank should have been documented on the MAR. During an interview with the Clinical		and will ensure that orders for supplements have been properly entered on the Medication Administration Record including a space for the percentage (%) of supplement consumed to be recorded. The Medication Administration Records will be reviewed three times weekly for four weeks to ensure the documentation of administration and percentage (%) of supplements are recorded, then every other week for four weeks, then monthly as part of the ongoing QA process. The QA committee will review audit reports and if negative trends are noted the QA committee will recommend changes in interventions. The effectiveness of those interventions will be assessed at the following monthy meeting to ensure the facility's policy and procedure for documentation of supplements and medication administration are followed.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Care Coordinator #11 on 4/13/11 at 10:35 a.m., she indicated the amount of Juven the resident consumed should have been documented on the MAR. She indicated the facility would have no way of knowing whether the intervention was effective without knowing how much the resident consumed. During an interview with the Director of Health Services (DHS) on 4/13/11 at 3:30 p.m., she indicated the amount of Juven the resident consumed should have been documented on the MAR. 2 A. Resident #24's record was reviewed on 4/14/11 at 11:00 a.m. Diagnoses included, but were not limited to, coronary artery disease, hypertension, hyperlipidemia, and aortic valve replacement. MAR dated 4/1/11 through 4/11/11 indicated the resident received "...Metolazone (blood pressure medication) 2.5 mg tablet. Give 1 tablet orally every other day for HTN...." Documentation was lacking to indicate the resident received the medication as ordered on 4/9, 4/11, and 4/13/11. 2 B. MAR dated 4/1/11 through 4/11/11 indicated the resident received "...Potassium CL 10 MEQ (millimeters			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155777	A. BUILDING 00 B. WING	04/15/2011

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	equivalent)...cap (capsules) give 2 capsules (20 MEQ) by mouth twice a day with meals for supplement..." Documentation was lacking to indicate the resident received the medication as ordered at bedtime on 4/9, 4/10, and 4/11/11. 3 B. MAR dated 4/1/11 through 4/11/11 indicated the resident received "...Lipitor (lipid reducing medication) 40 mg give 1 tablet by mouth every bedtime for hyperlipidemia..." Documentation was lacking to indicate the resident received the medication as ordered at bedtime on 4/10 and 4/11/11. During an interview with the Clinical Care Coordinator #11 on 4/13/11 at 10:35 a.m., she indicated there should be no holes in documentation on the MAR's. During an interview with the Clinical Care Coordinator #10 on 4/14/11 at 2:00 p.m., she indicated the medications had been given by the nursing staff but had not been signed off on the MAR. She indicated there should be no holes in the MAR's. A policy and procedure dated 2/1/10, titled "Medication Administration-General Guidelines" provided by the Executive Director on 4/14/11 at 1:55 p.m.,			

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	identified as current indicated "...The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure the necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications...." 3.1-50(a)(1) 3.1-50(a)(2)			